STATE FORM >

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIE DENTIFICATION NU			ER/CLIA IMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING O1 - MAIN BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		10/16/2012			
	HEALTH CARE CENTE	ER		LING LANE			
(X4) ID PREFIX YAG	i (EACH DEFICIENCY	FILL!	ID PROVIDER'S PLAN OF CORE PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE A DEFICIENCY)		HOULD BE	(XS) COMPL DATA	
	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY		facility fac	N 848	The facility will provide positive air pres- linen storage areas  The Administrator confirmed the finding correction will soustly Building Standard	and the	11/16/3
on of Heald	h Čare Facililles 💋	10				<u> </u>	